

Principles and Criteria by Which Performance Measures Will be Evaluated to Determine Their Readiness for Public Reporting by the Health Care Quality and Cost Council (HCQCC)

Approved (5/21/10) – with one proposed modification (6/25/10)

STATEMENT OF OBJECTIVES	
<p>The overarching goal of measuring, monitoring and reporting information on health care quality and costs is to help motivate continued meaningful progress toward the twin goals of <u>improving health care quality while reducing costs and cost growth</u>.</p> <ul style="list-style-type: none"> ▪ When publishing information about individual providers, provider groups or institutional providers, the measure set should encompass as broad a proportion of the provider's practice on the relevant condition(s) as possible. ▪ Ideally, the measures presented about a provider/organization should encompass performance on the following key domains: clinical (process and/or outcomes), patient experience and cost/resource use. ▪ The totality of measures presented with regard to a provider/organization should have some value and meaning for the intended audience. 	New
SPECIFIC CRITERIA FOR INDIVIDUAL MEASURES SEEKING APPROVAL	
1. Wherever possible, measures should be drawn from nationally accepted standard measure sets.	✓
2. The measure must reflect something broadly accepted as meaningful to providers or patients. <i>"Meaningfulness" is defined by NQF as "the extent to which the measure addresses one of the Institute of Medicine aims (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improved health outcomes for a high impact area in which there is variation in overall performance."</i>	Revised
3. There must be empirical evidence that the measure provides stable and reliable information, and that the data sources and sample sizes are sufficient for accurate reporting at the level chosen. Measures representing clinician performance should be reported at the physician group or practice level, not the individual clinician level, unless the statistical methodology for the measure allows stable and reliable information at the individual clinician level.	<p>Revised</p> <p>✓</p>
4. There must be empirical evidence that the	New

measure is a valid representation of the dimension of care that it purports to present. In establishing validity, evidence of criterion validity (i.e., reference against a gold standard – concurrent validity; predictive validity) is ideal, but any evidence of validity that goes beyond mere “face validity” (e.g., discriminant validity, convergent validity) will be considered.	
5. <i>With rare exceptions</i> , there <i>should</i> be sufficient variability or insufficient performance on the measure to merit attention. <i>Exceptions would be for topics deemed so essential to health outcomes or health care quality as to merit continuous monitoring even if performance is uniformly high.</i>	Revised
6. There must be empirical evidence that the measured entity (clinician, site, group, institution) is associated with a significant amount of the variance in the measure.	√
7. Where accountability is shared and/or a concept cannot be reliably measured at the provider/organizational level, consider reporting the measure at the community and/or state level in order to help establish attention to the issue and build accountability for improvement.	New
8. Providers should be informed about the development and validation of the measures and given the opportunity to view their own performance, ideally for one measurement cycle, before the data are used for public reporting. Where feasible, providers should be permitted to verify data and offer corrections.	√
9. The resource requirements for collecting and reporting the data necessary for the measure should be considered as part of the assessment and approval process for a measure.	New